FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0004630

Facility Name: Christian Nursing Home

Address: 1507 - 7th Street (Number) Lincoln (City) 62656 (Zip Code)

County: Logan

Telephone Number: 217-732-2189 **Fax #** ( )

IDPA ID Number: 37-0841562004

Date of Initial License for Current Owners: 09/01/65

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C)3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 1999 to June 30, 2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer
(Signed) (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,779	11,650	1,392	22,821	8
9	SNF/PED					9
10	ICF	2,895	5,248		8,143	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,674	16,898	1,392	30,964	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.46%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/01/65

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 36531 and days of care provided 365

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	147,618	29,529	9,382	186,529		186,529		186,529			1
2	Food Purchase		166,703		166,703		166,703		166,703			2
3	Housekeeping	97,054	20,492		117,546		117,546		117,546			3
4	Laundry	37,880	11,889		49,769		49,769		49,769			4
5	Heat and Other Utilities			87,612	87,612		87,612	74	87,686			5
6	Maintenance	67,273	9,385	42,159	118,817		118,817	5,831	124,648			6
7	Other (specify):*											7
8	**TOTAL General Services**	349,825	237,998	139,153	726,976		726,976	5,905	732,881			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,387,562	110,660	15,644	1,513,866		1,513,866		1,513,866			10
10a	Therapy			89,808	89,808		89,808		89,808			10a
11	Activities	27,804			27,804		27,804		27,804			11
12	Social Services	85,721	417	3,344	89,482		89,482		89,482			12
13	Nurse Aide Training											13
14	Program Transportation		2,727		2,727		2,727		2,727			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,501,087	113,804	108,796	1,723,687		1,723,687		1,723,687			16
	C. General Administration											
17	Administrative	78,240	911	134,784	213,935		213,935	(104,292)	109,643			17
18	Directors Fees											18
19	Professional Services			7,848	7,848		7,848	16,568	24,416			19
20	Dues, Fees, Subscriptions & Promotions			14,210	14,210		14,210	(4,588)	9,622			20
21	Clerical & General Office Expenses	83,051	3,823	25,405	112,279		112,279	16,697	128,976			21
22	Employee Benefits & Payroll Taxes			276,022	276,022		276,022	6,900	282,922			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,602	5,602		5,602	2,230	7,832			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			11,505	11,505		11,505	1,224	12,729			26
27	Other (specify):*											27
28	**TOTAL General Administration**	161,291	4,734	475,376	641,401		641,401	(65,261)	576,140			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,012,203	356,536	723,325	3,092,064		3,092,064	(59,356)	3,032,708			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Christian Nursing Home #0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			116,228	116,228		116,228	10,384	126,612			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,820	40,820		40,820	(40,820)				32
33	Real Estate Taxes			888	888		888		888			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			157,936	157,936		157,936	(30,436)	127,500			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,166	2,166		2,166		2,166			39
40	Barber and Beauty Shops			12,298	12,298		12,298		12,298			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):* **Apt/Congregate**			486,748	486,748		486,748		486,748			43
44	**TOTAL Special Cost Centers**			555,564	555,564		555,564		555,564			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,012,203	356,536	1,436,825	3,805,564		3,805,564	(89,792)	3,715,772			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(529)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,690	30		9
10	Interest and Other Investment Income	(37,475)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(3,345)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,934)	21		24
25	Fund Raising, Advertising and Promotional	(5,462)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	75			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (47,980)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(41,812)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (41,812)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (89,792)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Christian Nursing Home

ID# 0004630

Report Period Beginning: July 1, 1999

Ending: June 30, 2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Personal purchases	$ 75	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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30				30
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
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67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	75		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(529)	603	0	0	0	0	0	0	0	0	0	74	5
6	Maintenance	0	5,831	0	0	0	0	0	0	0	0	0	5,831	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(529)	6,434	0	0	0	0	0	0	0	0	0	5,905	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(104,292)	0	0	0	0	0	0	0	0	0	(104,292)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,568	0	0	0	0	0	0	0	0	0	16,568	19
20	Fees, Subscriptions & Promotions	(5,462)	874	0	0	0	0	0	0	0	0	0	(4,588)	20
21	Clerical & General Office Expenses	(4,859)	21,556	0	0	0	0	0	0	0	0	0	16,697	21
22	Employee Benefits & Payroll Taxes	0	6,900	0	0	0	0	0	0	0	0	0	6,900	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,230	0	0	0	0	0	0	0	0	0	2,230	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,224	0	0	0	0	0	0	0	0	0	1,224	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(10,321)	(54,940)	0	0	0	0	0	0	0	0	0	(65,261)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,850)	(48,506)	0	0	0	0	0	0	0	0	0	(59,356)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Christian Nursing Home # 0004630 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,690	6,694	0	0	0	0	0	0	0	0	0	10,384	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(40,820)	0	0	0	0	0	0	0	0	0	0	(40,820)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(37,130)	6,694	0	0	0	0	0	0	0	0	0	(30,436)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(47,980)	(41,812)	0	0	0	0	0	0	0	0	0	(89,792)	45

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes, Inc.	100.00%	$ 603	$ 603	1
2	V	6	Maintenance				5,831	5,831	2
3	V	17	Administrative	134,784			30,492	(104,292)	3
4	V	18	Directors						4
5	V	19	Professional Services				16,568	16,568	5
6	V	20	Fees/Subscriptions/Promo				874	874	6
7	V	21	Clerical				21,556	21,556	7
8	V	22	Employee Benefits	2,952			9,852	6,900	8
9	V	23	Inservice						9
10	V	24	Travel and Seminar				2,230	2,230	10
11	V	26	Insurance				1,224	1,224	11
12	V	30	Depreciation				6,694	6,694	12
13	V								13
14	Total			$ 137,736			$ 95,924	$ * (41,812)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: ne 30, 2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Not Applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1993-A GR Bonds	X		Debt Restructure	$2,494.00	01/01/93	$ 450,000	$ 399,038		0.0750	$ 30,105	1
2	1991-C GR Bonds	X		Debt Restructure	$6,096.00	07/01/91	573,010	570,598		0.0775	7,370	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$8,590.00		$ 1,023,010	$ 969,636			$ 37,475	9
	B. Non-Facility Related*											
10	1993-A GR Bonds		X	Debt Restructure	$277.00	01/01/93	50,000	44,337	01/01/18	0.0750	3,345	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$277.00		$ 50,000	$ 44,337			$ 3,345	14
15	TOTALS (line 9+line14)						$ 1,073,010	$ 1,013,973			$ 40,820	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,200 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Apartments
Congregate Building
Duplexes

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: None
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	43,560	Various	$ 83,965	1
2	Home Office			5,742	2
3	TOTALS	43,560		$ 89,707	3

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	48		1965	1965	$ 272,125	$ 20,549	40	$ 6,803	$ (13,746)	$ 217,037	4
5	26		1969	1969	282,500		36	7,847	7,847	217,211	5
6	25		1972	1972	318,878		33	9,663	9,663	236,881	6
7											7
8	Home Office				40,973	1,338		1,338		17,788	8
	Improvement Type**										
9	Building Improvement			1965	48,022		20			48,022	9
10	Building Improvement			1969	49,853		20			49,853	10
11	Building Improvement			1972	56,049		20			56,049	11
12	L/I Pre 1975			1975	22,324		20			22,324	12
13	L/I Pre 1975-76			1976	754		20			754	13
14	Insulation/Fire Doors			1979	11,989	266	45	266		5,608	14
15	Windows & Improvements			1980	36,891	1,054	35	1,054		22,134	15
16	Water Sentry			1980	604		5			604	16
17	Furnace			1981	2,005		15			2,005	17
18	Laundry Room			1981	4,253	125	24	177	52	3,363	18
19	Heating Control System			1982	19,238	160	20	160		16,915	19
20	Folding Door			1982	429	21	20	21		359	20
21	Cooling Unit			1982	7,070	4	15	4		7,070	21
22	Garage			1982	2,875		15			2,875	22
23	Roofing			1982	9,373		5			9,373	23
24	Call System			1982	1,025	5	15	5		1,025	24
25	Lights			1983	5,900	5	15	5		5,900	25
26	Parking Lot			1983	45,243		15			45,243	26
27	Landscaping			1983	2,882	6	10	6		2,882	27
28	Heating Control System			1983	8,969		15	5	5	8,969	28
29	Fan			1983	243	5	10	5		243	29
30	Cabinet Tops			1983	2,302	153	15	153		2,142	30
31	Call System			1983	6,229	4	15	4		6,229	31
32	Roof Repairs			1983	34,602	190	15	190		34,602	32
33	Office Lights			1984	487	1	10	1		487	33
34	Water Heaters			1984	2,661	20	15	20		2,661	34
35	A/C Units			1984	12,415		8			12,415	35
36	TOTAL (lines 4 thru 35)				$ 1,309,163	$ 23,906		$ 27,727	$ 3,821	$ 1,059,023	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Kitchen Doors			1984	2,008	100	20	100		1,608	9
10	Compartment			1984	264	6	10	6		264	10
11	Wallpapering			1985	5,014		5			5,014	11
12	Roof Repairs			1985	50,063		5			50,063	12
13	Glazing Panels			1985	17,986	719	25	719		10,785	13
14	Windows			1985	7,800	223	35	223		3,345	14
15	Condensing Unit			1985	1,735		10			1,735	15
16	Landscaping			1986	8,190		10			8,190	16
17	Building Improvement			1986	8,250	330	25	330		4,675	17
18	Lights Parking Lot			1986	341	23	15	23		324	18
19	Gravel Roof			1986	2,986	199	15	199		2,803	19
20	Access Panel			1986	111	6	20	6		84	20
21	A/C Unit			1986	10,500	525	20	525		7,306	21
22	Wall Cabinet			1986	191	1	10	1		191	22
23	Laundry Floor Cover			1986	1,157	3	5	3		1,157	23
24	Drapes			1986	2,282	2	5	2		2,282	24
25	Laundry Room			1986	26,110	1,306	20	1,306		17,743	25
26	Laundry Floor			1987	3,196		5			3,196	26
27	Sprinkler System			1987	120	6	20	6		80	27
28	Wall Bumper			1987	211	11	20	11		146	28
29	Fire Alarm			1987	499	25	20	25		332	29
30	Life Safety Work			1987	9,104	455	20	455		6,029	30
31	Life Safety			1987	266	27	10	27		181	31
32	Blacktop			1987	360		10			360	32
33	Shuttering			1987	893	45	20	45		589	33
34	Wallcovering			1987	285		5			285	34
35	Carpeting			1987	1,817	2	5	2		1,817	35
36	TOTAL (lines 4 thru 35)				$ 161,739	$ 4,014		$ 4,014	$	$ 130,584	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Beauty Shop Floor			1987	618		5			618	9
10	Remodeling			1987	200	20	10	20		140	10
11	Life Safety			1987	1,284	128	10	128		1,072	11
12	Chaplains Office			1987	667	2	5	2		667	12
13	Life Safety			1987	1,875	188	10	188		1,324	13
14	Cabinets Beauty Shop			1987	558	37	15	37		475	14
15	Glass Windows			1987	2,396	120	20	120		1,530	15
16	Lights			1987	364	4	10	4		364	16
17	Metal Door			1987	440	22	20	22		277	17
18	Water Heater			1987	4,701	1	10	1		4,701	18
19	Parking Lot Repair			1988	3,966		10			3,966	19
20	3-Ply Pitch Roof			1988	6,150	410	15	410		4,818	20
21	New A/C Work			1989	6,066	303	20	303		3,485	21
22	A/C System			1989	42,748	2,137	20	2,137		24,397	22
23	Landscaping Plants			1989	686	34	20	34		380	23
24	Ceiling Tiles			1989	351	1	5	1		351	24
25	Fire Dampers			1989	1,881	1	10	1		1,881	25
26	Replace Door			1989	657	33	20	33		360	26
27	Condensing Unit			1989	700		5			700	27
28	Sprinkler System			1989	4,106	205	20	205		2,221	28
29	Life Safety			1989	458	46	10	46		364	29
30	Stain Glass Windows			1989	475	43	10		(43)	475	30
31	Remodel Dining Room			1990	2,970	173	10	173		2,970	31
32	Circulating Pump			1990	705	47	15	47		478	32
33	Replace /Install Window			1990	710	20	35	20		202	33
34	Sign			1990	984	98	10	98		980	34
35	Doors			1990	508	25	20	25		248	35
36	TOTAL (lines 4 thru 35)				$ 87,224	$ 4,098		$ 4,055	$ (43)	$ 59,444	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roofing A/C			1990	1,732	115	15	115		1,140	9
10	Water Heater			1990	2,275	152	15	152		1,495	10
11	A/C Unit			1990	10,186	1,019	10	1,019		10,020	11
12	Wallpaper			1991	2,544		5			2,544	12
13	Modular Nurse Station			1991	9,321	932	10	932		8,664	13
14	Roll Cover Base			1991	599	60	10	60		560	14
15	Wallpaper			1991	1,807	2	5	2		1,807	15
16	Wallcoverings			1991	5,774		5			5,774	16
17	A/C Compressor			1991	7,007	701	10	701		6,426	17
18	Cafeteria Window			1991	711	20	35	20		182	18
19	Base Cabinet			1991	666	44	15	44		710	19
20	Roof Work			1991	2,900	193	15	193		1,673	20
21	Water Heater			1991	1,288	86	15	86		738	21
22	Remodeling 32 Rooms			1992	25,027	1,251	20	1,251		10,529	22
23	Life Safety			1992	814	81	20	41	(40)	338	23
24	Doors (5)			1992	2,550	128	20	128		1,056	24
25	Smoke Heads Fire Relay			1992	1,235	62	20	62		512	25
26	Land Clearing			1992	2,750	138	20	138		1,127	26
27	Cove Base (120')			1992	591	59	10	59		482	27
28	Install Sprinklers			1992	1,382	69	20	69		563	28
29	Life Safety			1992	973	97	20	49	(48)	392	29
30	Land Surveying			1992	600	30	20	30		237	30
31	Fencing			1992	542	54	10	54		423	31
32	Furnaces			1992	13,165	658	20	658		5,100	32
33	Wall Paper			1992	3,376	1	5	1		3,376	33
34	Carpeting			1993	5,313		5			5,313	34
35	Lighting			1993	954	95	10	95		697	35
36	TOTAL (lines 4 thru 35)				$ 106,082	$ 6,047		$ 5,959	$ (88)	$ 71,878	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Air Conditioner			1993	4,475	448	10	448		3,173	9
10	Reroof			1993	8,477	385	22	385		2,727	10
11	SW Roof			1993	900	41	22	41		280	11
12	Energy Management System			1994	19,170	351	20	351		5,482	12
13	Lighting Life Safety			1994	973	97	10	97		606	13
14	Panels/Base Dayroom			1994	860		5			860	14
15	Drive Up/Curb Canopy			1994	7,108	711	10	711		4,384	15
16	Door Alarms			1994	851	1	5	1		851	16
17	Doors			1994	1,319	132	10	132		781	17
18	Landscaping			1995	1,273	127	10	127		656	18
19	Parking Lot			1995	13,680	194	3	194		13,629	19
20	Front Entrance			1995	11,006	1,101	10	1,101		5,413	20
21	Roof			1995	6,300	1,260	5	1,260		5,985	21
22	Roof			1995	15,582	1,558	10	1,558		7,401	22
23	Front Entrance			1996	7,125	713	10	713		3,149	23
24	Roof Work			1996	3,400	680	5	680		2,777	24
25	Cnds. Unit-100			1996	2,742	274	10	274		1,119	25
26	Roof Work			1996	536	107	5	107		419	26
27	Roof Work Ewing			1996	3,062	612	5	612		1,295	27
28	Roof Repairs			1996	1,279	256	5	256		939	28
29	Lights & Dampers			1997	17,712	1,771	10	1,771		6,051	29
30	Courtyard Door			1997	972	97	10	97		283	30
31	Office Roof Work			1997	2,275	455	5	455		1,289	31
32	Roof Work 100 Wing			1997	13,120	1,312	10	1,312		3,717	32
33	Floor Covering			1997	2,091	418	5	418		1,015	33
34	Roof Work N&S Wing			1998	12,500	1,250	10	1,250		2,708	34
35	Page 12D (2) totals				865,430	22,869		22,869		20,354	35
36	TOTAL (lines 4 thru 35)				$ 1,024,218	$ 37,220		$ 37,220	$	$ 97,343	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	South Wing Roof Work			1998	14,800	1,480	10	1,480		1,529	9
10	A/C in Lobby			1998	1,226	123	10	123		133	10
11	Compressor - Laundry			1998	1,914	638	3	638		691	11
12	Roof Work			1999	1,920	384	5	384		384	12
13	Roof Work - Valley Area			1999	5,073	1,015	5	1,015		930	13
14	Carpeting 300 Wing			1999	11,167	2,233	5	2,233		1,675	14
15	A/C Unit 300 Wing			1999	4,284	428	10	428		321	15
16	Roof Work Dining Area			1999	6,590	1,318	5	1,318		989	16
17	Wallpaper 300 Wing			1999	12,512	2,502	5	2,502		1,459	17
18	Carpet Conference			1999	978	196	5	196		131	18
19	Carpet Lobby			1999	5,021	1,004	5	1,004		669	19
20	Carpeting			1999	3,473	695	5	695		348	20
21	Office A/C Unit			1999	2,715	272	10	272		113	21
22	Carpeting			1999	1,743	349	5	349		116	22
23	Roof Work			1999	3,665	733	5	733		183	23
24	Remodel Beauty Shop			1999	1,339	268	5	268		45	24
25	Storage Shed			1999	1,578	158	10	158		1,565	25
26	Roof work			2000	5,536	1,015	5	1,015		1,015	26
27	Opto 22 energy management			2000	14,795	740	15	740		740	27
28	AD Smith water heater			2000	3,195	240	10	240		240	28
29	Water heater			2000	5,590	326	10	326		326	29
30	Handwash station			2000	1,140	38	15	38		38	30
31	Kitchen expansion			2000	790,605	6,588	40	6,588		6,588	31
32	Wallcover Staff DR			2000	933	62	5	62		62	32
33	Storage cabs			2000	676	15	15	15		15	33
34	Condensing unit			2000	2,530	28	15	28		28	34
35	Page 12D (3) totals				(39,568)	21		21		21	35
36	TOTAL (lines 4 thru 35)				$ 865,430	$ 22,869		$ 22,869	$	$ 20,354	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Compressor laundry			2000	1,524	21	12	21		21	9
10											10
11	Less items disposed in 2000				(41,092)						11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	Page 12D (X) totals										35
36	TOTAL (lines 4 thru 35)				$ (39,568)	$ 21		$ 21	$	$ 21	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 306,320	$ 33,998	$ 33,998	$		$ 147,499	37
38	Current Year Purchases	148,361	4,022	4,022			4,022	38
39	Fully Depreciated Assets	154,374					154,374	39
40	Home Office Allocation	35,763	3,691	3,691			29,215	40
41	TOTALS	$ 644,818	$ 41,711	$ 41,711	$		$ 335,110	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transportation	1992 Bus	1992	$ 38,828	$ 2,828	$ 2,828	$	8	$ 38,828	42
43	Patient Transportation	1984 Merc. Gand Mrqus	1984	2,291				3	2,291	43
44	Patient Transportation	1985 Chevy Van Lift	1998	4,300	1,433	1,433		3	1,672	44
45	Home Office			7,788	1,665	1,665			4,137	45
46	TOTALS			$ 53,207	$ 5,926	$ 5,926	$		$ 46,928	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,476,158	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 122,922	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 126,612	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 3,690	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,800,310	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Apartment	$ 2,136,997	$ 70,280	$ 885,960	52
53	Congregate	2,067,249	65,382	819,885	53
54	Land	230,405			54
55					55
56					56
57	TOTALS	$ 4,434,651	$ 135,662	$ 1,705,845	57

G. Construction-in-Progress

	Description	Cost	
58	ALZ Unit	$ 1,271,685	58
59			59
60			60
61		$ 1,271,685	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 2,075	$	$ 2,075
2	Books and Supplies		200		200
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 2,275	$	$ 2,275
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,275			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$ N/A		$	$		$ #VALUE!	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,406	$	1
2	Cash-Patient Deposits	1,928		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 11,568)	236,251		3
4	Supply Inventory (priced at FIFO)	13,719		4
5	Short-Term Investments	6,818		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	3,302		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 266,424	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	314,369		13
14	Buildings, at Historical Cost	6,473,109		14
15	Leasehold Improvements, at Historical Cost	171,096		15
16	Equipment, at Historical Cost	861,958		16
17	Accumulated Depreciation (book methods)	(3,275,718)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,330,707		21
22	Other Long-Term Assets (sp Deferred Bond	10,357		22
23	Other(specify): CIP	1,271,686		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,157,564	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,423,988	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 135,684	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	103,286		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,329		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 240,299	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,013,973		41
42	Deferred Compensation	718,598		42
	Other Long-Term Liabilities(specify):			
43	Funds In Trust/Sec Dep	745,294		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,477,865	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,718,164	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,705,825	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,423,988	$	48

***(See instructions.)**

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,384,247	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,384,247	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	321,578	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 321,578	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,705,825	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,576,546	1
2	Discounts and Allowances for all Levels	(507,424)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,069,122	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	30,822	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 30,822	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	12,103	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,397	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 19,500	23
	D. Non-Operating Revenue		
24	Contributions	252,564	24
25	Interest and Other Investment Income***	119,361	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 371,925	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Residential & Congregate**	660,198	28
28a	**Unrealized G/(L) on Sale of Equip & Investments**	(24,425)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 635,773	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,127,142	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	726,976	31
32	Health Care	1,723,687	32
33	General Administration	641,401	33
	B. Capital Expense		
34	Ownership	157,936	34
	C. Ancillary Expense		
35	Special Cost Centers	501,212	35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,805,564	40
41	**Income before Income Taxes (line 30 minus line 40)****	321,578	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 321,578	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,787	1,970	$ 42,238	$ 21.44	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	8,392	9,249	199,497	21.57	3
4	Licensed Practical Nurses	24,627	27,142	399,748	14.73	4
5	Nurse Aides & Orderlies	74,017	81,577	724,089	8.88	5
6	Nurse Aide Trainees		0			6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides	1,964	2,165	21,990	10.16	8
9	Activity Director		0			9
10	Activity Assistants	2,735	3,014	27,804	9.22	10
11	Social Service Workers	9,608	10,589	85,721	8.10	11
12	Dietician		0			12
13	Food Service Supervisor		0			13
14	Head Cook		0			14
15	Cook Helpers/Assistants	17,300	19,067	147,618	7.74	15
16	Dishwashers		0			16
17	Maintenance Workers	5,553	6,120	67,273	10.99	17
18	Housekeepers	11,681	12,874	97,054	7.54	18
19	Laundry	4,341	4,784	37,880	7.92	19
20	Administrator	1,695	1,868	78,240	41.88	20
21	Assistant Administrator		0			21
22	Other Administrative		0			22
23	Office Manager	1,775	1,956	29,531	15.10	23
24	Clerical	5,578	6,148	53,520	8.71	24
25	Vocational Instruction		0			25
26	Academic Instruction		0			26
27	Medical Director		0			27
28	Qualified MR Prof. (QMRP)		0			28
29	Resident Services Coordinator		0			29
30	Habilitation Aides (DD Homes)		0			30
31	Medical Records		0			31
32	Other Health Care(specify)		0			32
33	Other(specify)		0			33
34	TOTAL (lines 1 - 33)	171,053	188,523	$ 2,012,203 *	$ 10.67	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	223	$ 9,382	1.3	35
36	Medical Director			9.3	36
37	Medical Records Consultant	22	1,330	39.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,200	10.3	39
40	Physical Therapy Consultant	340	20,254	10A.3	40
41	Occupational Therapy Consultant	454	21,657	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	183	10,580	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	48	2,794	12.3	45
46	Other(specify)				46
47	P.T. Asst.	956	37,317	10A.3	47
48					48
49	TOTAL (lines 35 - 48)	2,322	$ 104,514		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Timothy Searby	Administrator	0	$ 78,240
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,240

B. Administrative - Other

Description	Amount
Management Fee	$ 134,784
TOTAL (agree to Schedule V, line 17, col. 3)	$ 134,784
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mutual of Omaha	Medicare billing	$ 209
Manda K. Fuiten	Appraisal fees	1,500
Booth and Antoline	Legal fees	2,188
Systematic Management Services	Medicare recapture program	3,951
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 7,848

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,604
Unemployment Compensation Insurance	2,952
FICA Taxes	150,837
Employee Health Insurance	66,330
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	7,164
Employee Physicals	3,113
Related party adjustment	(2,952)
Home Office Allocation	9,744
Uniforms	35
Workers compensation medical expense	1,095
TOTAL (agree to Schedule V, line 22, col.8)	$ 282,922

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	765
Health Care Worker Background Check	
(Indicate # of checks performed)	
Promotion	5,462
Software and online fees	1,638
Other fees	448
Life serv. of Illinois dues	5,228
NAGNA dues	669
Home Office Allocation	874
Less: Public Relations Expense	(5,462)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,622

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	708
Seminar Expense	4,170
Self-study and books	724
Home Office Allocation	2,230
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,832

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: July 1, 1999 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **NAGNA $669**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,520** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **No** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **No** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,352**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **N/A - Will send when completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.